Your Honor,

Date: 1/15/2017

Pg. 1 of 5

Docket #: 16cv2517

The city of New York wrote me stating that they sent me forms to unseal the records of my Dec. 26, 2013 arrest. In writing to inform the court I have not received these forms that were allegedly sent on Dec. 12, 2016. However, I do not see how they are relevant to this civil matter. Now on Dec. 26 2013, even though the officer that brought me into the Emergency department in Bellevue acted as if I was in custody, I was not charged with any of the alleged criminal conduct that this officer told MD Chaput I was guilty of. The alleged conduct described to MD Chaput by this officer, which the Plaintiff supposedly exhibited, might have been criminal behavior punishable by law but plaintiff was never criminally charged stemming from his alleged behavior exhibited that day. I was arrested after I informed officers I'm not leaving the establishment they was dispatched to until they investigate the crime I just reported to them. I was in an asian restaurant on 9th ave between 24th and 25th St. and requested they call law enforcement when they refused to hand me my correct change. When NYPD arrived I informed the police that I handed the cashier a $20 dollar bill for a meal that was $6.97 and only received $3 dollars in change back. The cashier insisted I only handed her a $10 dollar bill. I informed the officers the camera facing the register

will Prove my allegations against this establishment (Showing the correct bill, dollar amount, handed to the cashier). The cashier shook her head no, suggesting she did not want to rewind the surveillance footage. The officers assured her she doesn't have to and then Informed me to leave. I Informed these officers Im not leaving until they Investigate and at that moment I was threatened by use of deadly force (officers at that point of the encounter grabbed their guns but did not draw their weapons). My response to the officer's actions was In the form of vesbal communication. I Informed the officers that If they Intended to Kill me then Kill me, I will not be Intimidated, and Im not leaving until I receive my correct change. When the officers threatened to use force, I was confused by their disposition at that moment. I only requested they order the establishment to rewind the Footage, which would of Proved my allegations, yet they refused to Investigate and was holding their guns demanding I leave In a threatening manner. When I Informed the officers Im not leaving a second time, they called me suicidal, swatted my pepsi for food and charge to the ground, and handcuffed me. I Informed officers Im not guilty of any crime and the arresting officer only responded by saying "your not going to jail". I found out my Intended destination when Ems arrived. I Informed Ems I didn't do anything to be arrested for the Purpose of Involuntary hospitalization but when they questioned Nypd they were told I was In custody.

pg. 3 of 5

I asked the EMS worker can he inform the officer that my handcuffs are not double locked and at the moment is starting to cut off my circulation. The EMS worker then informed the officer that the plaintiff will like his handcuffs readjusted because they are causing his hands to go numb. The officer ignored the EMS worker's request with a menacing glare. The EMS worker then informed me not to worry stating "The hospital is not far away, were almost there." When I arrived at Bellevue, I was brought into the Emergency department by the officer that rode in the ambulance with me. When I got to the waiting area of the Emergency department, after a couple of minutes, I was greeted by MD Fierce Cheput. She initially questioned the officer, inquiring why was the plaintiff brought to the hospital? The officer falsely informed MD Cheput that the plaintiff didn't pay for his food, was breaking things, and suggested to the doctor that she should give the plaintiff something to calm him down. MD Cheput then asked the plaintiff his version of events. I informed MD Cheput that I did pay for my food and I was not breaking things, contrary to the officer's version. The officers told the doctor "he's lying", as I was trying to explain to MD Cheput why the officer's version was not plausible, I was distracted by the tightness of the handcuffs, that was causing my hands to go numb. At that moment I asked the officer to unhandcuff me because my hands was losing circulation. I was told no and again started to provide the Doctor with reasonable facts

which would of been perceived to a reasonable person as the truth. Because my explanation of the Incident was detailed and the officer only stated "he lying", as I was explaining my version. when I told MO chaput that the video footage at the restaurant will prove my version of events, the officer purposely squeezed the handcuffs so they will tighten up even more. at that moment I asked the officer again to remove the handcuffs and reminded him Im not guilty of any crime he can prove (I paid for my food, I did not destroy any property In the restaurant, and the correct denomination of currency I handed the cashier IS on video). The officer knew of all this and still refused to unhandcuff me. when the officer refused a second time, I told the officer "your a bitch, Im not arrested, Im not guilty of any crime, and you wont unhandcuff me your abusing your authority." MO chaput then agreed at that time to the officer's suggestion to forcibly medicate me, telling the officer he can remove the handcuffs, and that she will give me something to calm me down. at that time, I was no longer In Police custody and was now being falsely Imprisoned by the hospital. I was never criminally charge your honor, however I complied with The city of New york request and signed 160.50 release forms/medical release forms. Even though, since I wasnt criminally charge there will be no sealed records pursuant to 160.50 and I have already submitted the medical records from the Incident to the court. So the records

Pg. 4 of 5

that are being requested by the defendants are already available to all parties involved. your honor I would like for this civil matter to have no delays in litigation and thats the very reason I did my best to submit every record I tried so diligently to obtain to the court. I hope this request made by the city of new york isn't just another tactic to delay litigation of this matter and request another enlargement to comply with the valentin order. however all forms that the city of new york is requesting the plaintiff sign, has been signed, and was sent via U.S. mail Jan. 17, 2017.

pg. 5 of 5

Print name: Robert Lurch

Signature: Robert Lurch

Date: 1/15/2017

Docket#: 16cv2517

Mag: Stretch S.: S.F.

Parties: MO Chaput, RN Marquez, NYCHHC, The city of new york

Documents

copies of the signed forms that were sent to The city of new york/Law department/100 church st./New York, NY/10007 are included with this letter.

ZACHARY W. CARTER
Corporation Counsel

The City of New York
LAW DEPARTMENT
100 CHURCH STREET
NEW YORK, N.Y. 10007

MARINA ZUYEVA
212-356-2653
Fax: 212-356-3509
mzuyeva@law.nyc.gov

January 9, 2016

Robert Lurch Jr. (16A2468)
Plaintiff PRO SE
Franklin Correctional Facility
62 Barehill PO Box 10
Malone, NY 12953

Re: Robert Lurch, Jr v. The City of New York, et al.
16CV2517

Dear Mr. Lurch Jr. :

This office is in receipt of the complaint in the above-referenced action. The complaint alleges physical and/or emotional injuries as a result of the incident described in the complaint. In order for this lawsuit to proceed, the medical records pertaining to the incident described in the complaint must be available to defendants. Enclosed please find a medical release form.

Please execute the release before a notary public and return the release to me within one week of the above date. On the release, you should provide the name and address of the medical provider, the date or dates of treatment, your social security number and your date of birth. The social security number and the date of birth are needed so that the medical provider can identify the proper records, which concern your treatment. Until the executed release is received by this office, we cannot secure the relevant medical records. Consequently, we will not be able to properly assess this case, or proceed to discovery. Your failure to promptly return this release will unduly delay this litigation. If you have any questions, please do not hesitate to call me.

Thank you for your attention to this matter.

Very truly yours,

Marina Zuyeva
Paralegal
Special Federal Litigation Division

Enc.
cc: Christopher G. Arko
Assistant Corporation Counsel

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

----------x

Robert Lurch, Jr. ,

Plaintiff,

-against-

City of New York, et al.,

Defendants

----------x

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

16CV2517 (AT) (JCF)

TO: Bellevue Hospital Center/462 First avenue/New York, NY/10016
NAME AND ADDRESS OF MEDICAL PROVIDER

I authorize the use and disclosure of ROBERT LURCH JR. 'S health information as described below.

YOU ARE HEREBY AUTHORIZED to furnish to ZACHARY W. CARTER, Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a **CERTIFIED COPY** of the entire medical or hospital record of ROBERT LURCH JR. (Date of Birth: 11/28/90 ; SS #: 086-80-3660) who was examined or treated in your hospital or by you on or about 12/26/13.

The medical record authorized for release includes any and all x-rays of said person and any and all diagnostic tests, studies, or reports of examinations relating to such person.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol, and drug abuse.

This information may be disclosed to and used by the following organization:
The Office of the Corporation Counsel
100 Church Street
New York, NY 10007
for the purpose of defense of civil litigation

I understand I have the right to revoke this authorization at any time. In understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. Unless otherwise revoked, this authorization will expire on the following date, event or condition: 4/14/2017. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorization the disclosure of this health information is voluntary, I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact (Name of Medical Provider's Risk Management Office).

Dated: New York, New York
Jan. 14, 2017

Robert Lurch
ROBERT LURCH JR.

STATE OF NEW YORK)
: SS:
COUNTY OF Franklin)

On the 14th day of January, 2017, before me personally came and appeared ROBERT LURCH JR. , to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he executed the same.

Deborah A. Gumbus
NOTARY PUBLIC

DEBORAH A. GUMBUS
NOTARY PUBLIC,STATE OF NEW YORK
QUALIFIED IN FRANKLIN COUNTY
NO. 01GU6304688
COMMISSION EXPIRES JUNE 02,20 18

HHC

NYCHHC HIPAA Authorization to Disclose Health Information

ALL FIELDS MUST BE COMPLETED

THIS FORM MAY NOT BE USED FOR RESEARCH OR MARKETING, FUNDRAISING OR PUBLIC RELATIONS AUTHORIZATIONS

PATIENT NAME/ADDRESS	DATE OF BIRTH	PATIENT SSN
Robert Derek Leach Sr./Franklin Correctional Facility/62 Bare Hill Rd., P.O. Box 10/Malone, New York/12953	11/28/1990	086-80-3060
	MEDICAL RECORD NUMBER	TELEPHONE NUMBER

NAME OF HEALTH PROVIDER TO RELEASE INFORMATION	SPECIFIC INFORMATION TO BE RELEASED:
Bellevue Hospital Center	Information Requested Treatment Dates from 12/21/13 to 12/27/13
NAME & ADDRESS OF PERSON OR ENTITY TO WHOM INFO. WILL BE SENT Zachary W. Carter/Corporation Counsel/100 Church St./New York, NY/10007	INFORMATION TO BE RELEASED (If the box is checked, you are authorizing the release of that type of information). **Please note: unless all of the boxes are checked, we may be unable to process your request.** ☑ Alcohol and/or Substance Abuse Program Information ☑ Mental Health Information ☑ Genetic Testing Information ☑ HIV/AIDS-related Information
REASON FOR RELEASE OF INFORMATION ☑ Legal Matter ☐ Individual's Request ☐ Other (please specify):	WHEN WILL THIS AUTHORIZATION EXPIRE? (Please check one) ☐ Event: ☑ On this date: 4/14/2017

I, or my authorized representative, authorize the use or disclosure of my medical and/or billing information as I have described on this form.

I understand that my medical and/or billing information could be re-disclosed and no longer protected by federal health information privacy regulations if the recipient(s) described on this form are not required by law to protect the privacy of the information.

I understand that if my medical and/or billing records contain information relating to **ALCOHOL** or **SUBSTANCE ABUSE, GENETIC TESTING, MENTAL HEALTH**, and/or **CONFIDENTIAL HIV/AIDS RELATED INFORMATION**, this information will not be released to the person(s) I have indicated unless I check the box(es) for this information on this form.

I understand that if I am authorizing the use or disclosure of HIV/AIDS-related information, the recipient(s) is prohibited from using or re-disclosing any HIV/AIDS-related information without my authorization, unless permitted to do so under federal or state law. I also understand that I have a right to request a list of people who may receive or use my HIV/AIDS-related information without authorization. If I experience discrimination because of the use or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 212.480.2493 or the New York City Commission of Human Rights at 212.306.7450. These agencies are responsible for protecting my rights.

I understand that I have a right to refuse to sign this authorization and that my health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form. I also understand that if I refuse to sign this authorization, NYCHHC cannot honor my request to disclose my medical and/or billing information.

I understand that I have a right to request to inspect and/or receive a copy of the information described on this authorization form by completing a Request for Access Form. I also understand that I have a right to receive a copy of this form after I have signed it.

I understand that if I have signed this authorization form to use or disclose my medical and/or billing information, I have the right to revoke it at any time, except to the extent that NYCHHC has already taken action based on my authorization or that the authorization was obtained as a condition for obtaining insurance coverage.

To revoke this authorization, please contact the facility Health Information Management department processing this request.

I have read this form and all of my questions have been answered. By signing below, I acknowledge that I have read and accept all of the above.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE	IF NOT PATIENT, PRINT NAME & CONTACT INFORMATION OF PERSONAL REPRESENTATIVE SIGNING FORM
Robert Leach	
DATE	DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT ON BEHALF OF PATIENT
1/14/2017	

If HHC has requested this authorization, the patient or his/her Personal Representative must be provided a copy of this form after it has been signed.

HHC USE ONLY	
Date Received:	Initials of HIM employee processing request:
Date Completed:	Comments:

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health)

Patient Name	Date of Birth	Social Security Number
Robert Derek Lurch Sr.	11/28/1990	086-80-3060

Patient Address: Franklin Correctional Facility/62 Bare Hill Rd., P.O. Box 10/Malone, New York/12953

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Bellevue Hospital Center/462 First avenue/New York, NY/10016

8. Name and address of person(s) or category of person to whom this information will be sent:
Zachary W. Carter/Corporation Counsel/100 Church Street/New York, NY/10007

9. (a). Specific information to be released:

☑ Medical Record from (insert date) 12/24/2013 to (insert date) 12/27/2013

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

Include: *(Indicate by Initialing)*

R.L. **Alcohol/Drug Treatment**

R.L. **Mental Health Information**

R.L. **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a government agency, listed here:

_____

(Attorney/ Firm Name or Government Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☑ At request of individual ☐ Other:	4/14/2017
12. If not the patient, name of person signing form:	13. **Authority** to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Robert Lurch — Date: 1/14/2017

Signature of patient or representative authorized by law.

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is a product of a collaborative process between New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filing out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

ZACHARY W. CARTER
Corporation Counsel

The City of New York
LAW DEPARTMENT
100 CHURCH STREET
NEW YORK, N.Y. 10007

MARINA ZUYEVA
212-356-2653
Fax: 212-356-3509
mzuyeva@law.nyc.gov

January 9, 2017

Robert Lurch Jr. (16A2468)
Plaintiff PRO SE
Franklin Correctional Facility
62 Barehill PO Box 10
Malone, NY 12953

Re: Robert Lurch, Jr v. The City of New York, et al.
16CV2517

Dear Mr. Lurch Jr. :

On December 12, 2016, this office forwarded to your attention a "Designation of Agent for Access to Sealed Records Pursuant to NYCPL §§ 160.50 and 160.55," so that the records pertaining to your arrest could be unsealed and so that this lawsuit could proceed in a timely fashion. To date, we have received neither a signed designation nor a response to our previous letter.

As you have been informed, until the executed designation is received by this office, we cannot secure the relevant documents. Consequently, we have been unable to properly assess this case, or to respond to the complaint or discovery requests. Your failure to promptly return this designation continues to delay this litigation. **Unless the executed and completed designation including the title of the proceeding, date of the arrest and docket or indictment number** is returned to this office within seven days of the date of this letter, we will make application to the Court for an order compelling the production of the executed designation.

For your convenience, I have enclosed another designation form. Thank you in advance for your prompt attention to this matter.

Very truly yours,

Marina Zuyeva
Paralegal
Special Federal Litigation Division

Enc.
cc: Christopher G. Arko
Assistant Corporation Counsel

DESIGNATION OF AGENT FOR ACCESS TO SEALED RECORDS PURSUANT TO NYCPL 160.50 AND 160.55

I, Robert Lurch Jr. , Date of Birth 11 / 28 / 1990 SS# 086 - 80-3060 pursuant to CPL §§ 160.50 and 160.55, hereby designate ZACHARY W. CARTER, Corporation Counsel of the City of New York, or his authorized representative, as my agent to whom records of the criminal action terminated in my favor entitled People of the State of New York v.Robert Lurch Jr. , Docket No. or Indictment No. _____, in _____ Court, County of _____, State of New York, relating to my arrest on or about December 26, 2013, may be made available.

I understand that until now the aforesaid records have been sealed pursuant to CPL §§ 160.50 and 160.55, which permits those records to be made available only (1) to persons designated by me, or (2) to certain other parties specifically designated in that statute.

I further understand that the person designated by me above as a person to whom the records may be made available is not bound by the statutory sealing requirements of CPL §§ 160.50 and 160.55.

The records to be made available to the person designated above comprise all records and papers relating to my arrest and prosecution in the criminal action identified herein on file with any court, police agency, prosecutor's office or state or local agency that were ordered to be sealed under the provisions of CPL §§ 160.50 and 160.55.

Robert Lurch
Robert Lurch Jr.

STATE OF NEW YORK)
: SS.:
COUNTY OF Franklin)

On this 14th day of January, 2017, before me personally came Robert Lurch Jr. , to me known and known to me to be the individual described in and who executed the foregoing instrument, and he acknowledged to me that he executed the same.

Deborah A. Gumbus
NOTARY PUBLIC

DEBORAH A. GUMBUS
NOTARY PUBLIC,STATE OF NEW YORK
QUALIFIED IN FRANKLIN COUNTY
NO. 01GU6304688
COMMISSION EXPIRES JUNE 02,20 18

LIN CORRECTIONAL FACILITY
E HILL ROAD, P.O. BOX 10
NE, NEW YORK 12953

Robert Lusch DIN: 16A2468

FRANKLIN CORRECTIONAL FACILITY

neopost
01/17/2017
US POSTAGE $000.67⁵

ZIP 12953
041L11251101

USM 83
SDNY

Pro Se Intake Unit
United States District Court
Southern District of New York
500 Pearl Street
New York, NY
10007

10007$1315 C014

Printed on Recycled Paper

NAME: Robert Lusch DIN: 16A2468

DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION
OFFENDER CORRESPONDENCE PROGRAM
NEW YORK STATE